

American Academy of Pediatrics, Maryland Chapter Final Report

April 14, 2009

The 426th General Assembly Session adjourned *Sine Die* at midnight on Monday April 13th. It was a Session dominated by budget challenges and fiscal constraints and therefore little new programmatic development. Despite these challenges, a number of issues of importance to MDAAP and its members were successfully addressed. This report reflects issues of specific relevance to pediatricians and their patients as well as issues of common interest to the practice of medicine.

Issues of Specific Relevance to Pediatrics:

1. Child Fatality Review Case Reporting System – House Bill 705/Senate Bill 862 – *Child Fatality Review – Child Fatality Review Case Reporting System* was introduced at the request of MDAAP. It will enable Maryland's child fatality review teams to utilize the National Center for Child Death Review Reporting System. Use of this system will not only enable Maryland to track its experience with national trends but will also allow the computerization of its own State and local review teams thereby enhancing the quality of their work. It represents a tremendous enhancement of Maryland's commitment to reduce child fatalities.
2. Teen Driver Safety – House Bill 303/Senate Bill 265 – *Vehicle Laws Teen Driver Safety* was an Administration initiative aimed at improving the safety of our young drivers. The bill (1) increases by three months the age limit for issuance of a provisional driver's license and driver's license; (2) authorizes the Motor Vehicle Administration (MVA) to cancel the license of a minor on request of the person who cosigned the minor's driver license application and provides for re-issuance of a minor's cancelled license; (3) establishes new penalties against the provisional license of persons younger than 18 who commit two or more moving violations including the imposition of an education and employment only restriction; and (4) requires MVA to submit an application for criminal history records check for a driving instructor candidate.
3. Newborn Screening - House Bill 180/Senate Bill 160 – *Hereditary and Congenital Disorder – Newborn Screening* was defeated. The legislation would have bifurcated Maryland's screening program into "treatable disorders" that would have been compulsory and disorders without "effective treatment" which would have required consent. The bifurcation of the consent process would, undoubtedly, have led to the screening of fewer babies. Maryland's program remains a national model and fortunately the General Assembly defeated this legislation and the program remains intact.
4. Student Health and Fitness – House Bill 1264/Senate Bill 879 – *Gwendolyn Britt Student Health and Fitness Act* was enacted into law. This has been a priority issue for the Academy for several years. While the legislation is not as strong as MDAAP would have ideally preferred, it is an excellent start in the right direction. The bill authorizes local school systems to develop and implement annual wellness policy implementation and monitoring plans. The Maryland State Department of Education (MSDE) is required to take specified steps to support the establishment of the plans. Local school systems that implement the plans must submit the plans to MSDE as well as annual progress reports. MSDE is also to establish an Advisory Council on Health and Physical Education on which MDAAP will hold a seat. The Advisory Council is required to develop and coordinate programs to educate students about the importance and benefits of physical movement. It advances the policy goals of the Academy and the late Senator Gwendolyn Britt for whom it is named.
5. Athletic Trainers – House Bill 173/Senate Bill 247 –*Health Occupations – Maryland Athletic Trainers Act* was also enacted. This legislation, supported by MDAAP provides a framework for the licensure of athletic trainers.

6. Autism – House Bill 503/Senate Bill 963 – *Maryland Commission on Autism* was enacted. The Commission has a large multi-disciplinary membership, most of whom are to be appointed by the Governor, and which includes a pediatrician. The Commission is to be jointly staffed by DHMH and MSDE and is charged with developing plans and recommendations relative to the care and treatment of those with autism spectrum disorders as well as make recommendations on how to increase awareness about autism spectrum disorders.
7. Foster Kids - House Bill 580 – *Foster Kids Coverage Act* was passed. It will enable foster children to continue to receive Medicaid benefits until age 21. The number of children affected is small but will provide an extra level of support for these children as they seek to develop the ability to support themselves and live independently.
8. Emergency Preparedness – House Bill 712/Senate Bill 356 – *Family Day Care Homes and Child Care Centers – Emergency Preparedness Plans* was enacted and requires MSDE to develop regulations that require family day homes and child care centers to have plans for emergency situations that require evacuation, sheltering in, or other child protective actions.
9. Internet Safety – Senate Bill 500 – *Online Child Safety Act of 2009* passed and requires all internet providers to make parental controls available to their subscribers.
10. Unsuccessful Initiatives: There were a number of initiatives that MDAAP supported but were not advanced this year such as all-terrain vehicle safety requirements, enhanced enforcement rights for local jurisdictions in the sale of tobacco products to minors, lead dust testing requirements, and the tax treatment of “alco-pops.” These are initiatives that will undoubtedly return in the 2010 legislative session.

Budget Issues of Relevance to Pediatrics:

Medicaid: The budget preserved funding for low-income Marylanders. Medicaid funding will grow over \$230 million, and there was no reduction in services or eligibility for services. Funding in FY 2010 includes \$650 million from the higher federal match established under the American Recovery and Reinvestment Act.

Babies Born Healthy: The General Assembly recognized the importance of assuring funding for the Babies Born Healthy Grant recipients and for the coordination of infant mortality initiatives by specifying the use of specific funds for those purposes. The fiscal 2010 budget allowance allocates \$665,000 of the funds provided to the Office of Minority Health and Health Disparities that the Babies Born Healthy Initiative depends on to fund the second year of grant funding to entities receiving a three-year grant award in fiscal 2009. The language restricts the funding allocated to the Office of Minority Health and Health Disparities to be used solely to fund the grants awarded by the Babies Born Healthy Initiative. DHMH administers two infant mortality programs, and the General Assembly would like to ensure these programs are working together to make the best use of the funding available. The language requires a report to be submitted November 1, 2009, to provide a status report to the budget committees about the two infant mortality programs, how the funds have been allocated, and how the programs are working together.

Issues Relevant to the Practice of Medicine Generally (borrowed in large measure from Med Chi's Legislative Report)

Two years ago, Med Chi convinced the O'Malley Administration to introduce legislation to create the Governor's Task Force on Health Care Access and Reimbursement (dhmh.maryland.gov/hcar/). That Task Force met from the fall of 2007 until the early winter of 2008 and made a number of significant proposals to improve the status of Maryland's physicians. Those proposals were contained in the final report and recommendations of the Task Force (December 2008 – dhmh.maryland.gov/hcar/html/reports) and resulted in the initiation of several legislative initiatives including the following:

1. Senate Bill 627 / House Bill 714 (*Loan Assistance Repayment and Practice Assistance for Physicians*) was enacted which provides for the creation of a state specific loan assistance program for physicians who will practice in a state defined shortage area. The legislation is particularly directed toward primary care which is broadly defined as including family medicine, internal medicine, obstetrics, pediatrics, geriatrics, emergency medicine and psychiatry. There currently exists a federal program for loan assistance repayment but it is extremely limited with respect to the practice type and geographical areas covered as well as the monies dispensed. The intent of the Task Force legislation was to create a well-funded state program by the assessment on all hospital bills in Maryland of .1% to fund the program. It is estimated that such an assessment will raise between \$10-13 million per year (as opposed to the present \$500,000 received from the federal program in 2008). While Senate Bill 627 / House Bill 714 have established the legal vehicle for the new program, it will be up to Health Secretary John Colmers to persuade Federal CMS officials that an assessment on hospital rates for these purposes is acceptable in light of the rules regarding Maryland's unique Medicare waiver with respect to its hospital rate setting system. In essence, Secretary Colmers will have to demonstrate that assisting primary care physicians will be beneficial to controlling the hospital costs in Maryland. As Chairman of the Governor's Task Force, he is firmly dedicated to this goal and, hopefully, Maryland will have this assistance program up and running in short order.
2. Senate Bill 380 / House Bill 255 (*Health Maintenance Organizations - Payments to Nonparticipating Providers*) establishes a new payment methodology for non-par doctors treating Maryland HMO patients. Since doctors are not allowed to "balance bill" HMO patients, the Legislature has required HMOs to pay charges according to a statutory formula. The Governor's Task Force "increased" this statutory formula in order to arrive at what it felt was a fair reimbursement schedule. It was projected by the Task Force that the additional compensation to doctors will be between \$17-25 million annually as a result of the new formula. Essentially, for certain codes (evaluation and management), the new formula requires the HMO to pay the greater of 140% of Medicare or 125% of the average rate paid to a contracting doctor. For all other codes, the new formula requires HMOs to pay 125% of the average paid to contracting doctors. While the 125% calculation existed in the past, most HMOs would figure the 125% on the basis of the lowest contract and not on the basis of the average contract. Experience indicates that the change from "lowest" to "average" will increase reimbursement by approximately 10% over present levels.
3. Senate Bill 661 / House Bill 526 (*Health Insurance - Use of Physician Rating Systems by Carriers*) was enacted and provides that insurance carriers who use "rating systems" of physicians will be required to observe detailed guidelines and to provide and pay for an "independent ratings examiner" to determine whether a rating is correct or not. The legislation provides detailed guidelines requiring a carrier to disclose clearly to enrolling physicians what portion of a physician's rating results from "cost efficiency" as opposed to "quality of performance." Moreover, "quality of performance" must be based on recognized evidence-based or consensus-based clinical guidelines. A physician will be entitled to receive detailed information as to how his or her "ranking" was determined and a ranking must make appropriate risk adjustments to account for patient population.

This legislation basically codifies the Consent Agreement reached between the Attorney General of the State of New York and various national insurance carriers which was the result of complaints from the New York Medical Society that ratings were unfair and slanted toward "cost" as opposed to "quality" indices.

4. Senate Bill 646 / House Bill 526 (*Credentialing of Health Care Providers by Managed Care Organizations, Insurance Carriers, and Hospitals*) was enacted and designed to assist the speed of credentialing activities by recognizing certain uniform credentialing forms to be used by insurers (including managed care organizations) and hospitals. Major challenges with respect to credentialing remain because of the different requirements applicable to hospitals as opposed to

insurance intermediaries and, further, because of the requirement of primary source verification where there is no accepted repository for primary source information.

While the Governor's Task Force formed the predicate for most of MedChi's positive Legislative Agenda, other initiatives were actively promoted, including Senate Bill 852 / House Bill 1647 (*Health Insurance - Assignment of Benefits - Notice and Report*). The principal reason that this legislation was not successful was the concern of legislators that the bill will encourage doctors to become non participating (because they will receive an insurance check whether they are participating or not) and, as a non participating doctor, will "balance bill" patients for the amount of their bill which is not covered by the assigned insurance benefit. It appears that very few assignment of benefits laws have passed in the 50 states. When it became clear that the legislation would not be favorably enacted, MedChi persuaded Thomas "Mac" Middleton, the Chair of the Senate Finance Committee, and Peter A. Hammen, Chair of the House HGO Committee, to write a joint letter requesting that the issue be studied over the interim leading up to the 2010 Session by the Joint Committee on Health Care Delivery & Financing. This is the same committee that studied the Maryland small group insurance market last year and came up with legislative reform of that market which is described below. We believe that the interim study will serve as a springboard for success in 2010.

The subject of electronic health records was addressed by Senate Bill 744 / House Bill 706 (*Electronic Health Records - Regulation and Reimbursement*) which was enacted and provides the development of regulations by the Maryland Health Care Commission directing insurance payers to provide "incentives" (increased reimbursement) to physicians to develop electronic health records. The Maryland Health Care Commission and various elected officials recognize the "cost" of electronic health records is borne by physicians with considerable benefits to health insurance carriers. The purpose of Senate Bill 744 / House Bill 706 is to provide a process by which the various insurance payers recognize and pay for the benefits they receive from electronic health records and further, a deadline for all physicians who participate with insurance carriers to switch to interchangeable electronic health records. The state initiative will be coordinated with the recent federal legislation. MedChi added amendments to this legislation to "exempt" physicians who do not participate with insurance companies and, further, to delay any implementation of a state only system until the federal law mandates are effective.

The "Bad Ones" That Didn't Get Away

The "bad" bills were many in 2009 but none was more significant than the #1 priority of the Maryland Trial Lawyers Association which was House Bill 237 / Senate Bill 505 (*Health Care Malpractice - Noneconomic Damages*). These proposals would have doubled the allowable cap on noneconomic damages in a wrongful death case (the cap in wrongful death actions is presently \$825,000 and it would have been doubled to \$1,750,000 if this legislation passed). The trial lawyer argument is that in all other wrongful death actions – except those arising from medical malpractice – the higher dollar amount applies. The successful MedChi argument was that "medical malpractice" cases deserved special treatment because there had been special problems over the years with the latest iteration being the Special Session on medical malpractice called by Governor Ehrlich in 2004/2005. That Special Session resulted in the passage of House Bill 2 which **reduced** the wrongful death amount from the higher level to the present level. Indeed, this was one of the principal "tort reforms" in House Bill 2 and the trial lawyers were seeking to undo it. House Bill 237 had a number of sponsors including 10 members of the 22 member House Judiciary Committee and seemed poised for passage.

MedChi lobbyists approached House Speaker Michael E. Busch, who had been one of the principal architects of House Bill 2 and was committed to preserving the reforms. Because of his direct intervention, House Bill 237 never received a vote as he indicated to the House Judiciary Committee leadership that he would be voting against their bill if it was reported to the floor favorably (it is an extremely unusual occurrence for the House Speaker to vote against a bill favorably reported by a House Committee).

House Bill 155 (*Physicians - Licensure - Liability Coverage*) and House Bill 1198 (*Physicians - Outpatient Surgical Services - Hospital Privilege*) were related “bad” bills. In its original form, House Bill 155 would have required all doctors in Maryland to secure medical malpractice insurance as a condition of licensure. House Bill 1198 would have required any doctor performing outpatient surgery to have hospital privileges. Both of these bills were generated by the activities of a plastic surgeon in Baltimore County which resulted in the death of a patient. It turned out that the plastic surgeon had neither hospital privileges nor malpractice insurance. It appears that House Bill 1198 also had an additional motive which was to discourage or limit certain physicians from performing certain procedures.

House Bill 1198 was withdrawn by its sponsor after a hearing in which MedChi raised numerous objections. House Bill 155 – despite MedChi’s objection – passed the House of Delegates although in a substantially amended form. As passed by the House of Delegates, the malpractice insurance requirement would have only been applicable to those physicians performing surgery in an “ambulatory surgery center.” Despite these amendments, MedChi’s objections continued, particularly as passage of the bill would have resulted in a first time ever requirement for malpractice insurance as a condition of medical licensure. The Senate EHE Committee agreed with MedChi and turned thumbs down on the bill.

The same committee had also rejected Senate Bill 882 (*Physicians - Professional Liability Insurance Coverage - Notification and Posting Requirements*). Senate Bill 832 required a physician to disclose to patients the absence of medical malpractice insurance. MedChi preferred the disclosure approach to the approach promulgated by House Bill 155.

Finally, particularly “bad bills” were the Governor’s False Claims bills (Senate Bill 272 / House Bill 304 - *Maryland False Health Claims Act of 2009*) as well as related, but even more expansive, measures (Senate Bill 830 / House Bill 915 - *Maryland False Claims Act*). These were a cluster of bills which would have allowed “whistleblower” lawsuits against hospitals, doctors and pharmaceutical companies for alleged fraud. Fraud, of course, is in the eye of the beholder and many “fraud” cases are really billing disputes between an insurance company and a physician’s practice. The main entry in this debate was Senate Bill 272 which was part of Governor O’Malley’s Administration package. It died on the floor of the Senate by a vote of 23 – 24 and was never resurrected. Perhaps in retribution, the Governor’s budget reduced hospital payments by \$10 million and physician Medicaid reimbursement by \$4.5 million. While such amounts may seem substantial, these “cuts” will be for one year only and the defeated bill would have been forever.